STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155236	A. BUILDING 00 B. WING	07/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVON HEALTH & REHABILITATION CENTER	4171 FOREST POINTE CIRCLE AVON, IN46123

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: July 18, 19, 20, 21, 22, 25, 2011 Facility number: 000141 Provider number: 155236 AIM number: 100293860 Survey team: Rita Mullen, RN, TC Janet Stanton, RN Census bed type: SNF/NF: 124 Total: 124 Census payor type: Medicare: 13 Medicaid: 82 Other: 29 Total: 124 Sample: 24 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed 7/27/11 Cathy Emswiller RN	F0000	This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law, and not because Avon Health and Rehabilitation Center agrees with the allegations contained there in. Avon Health and Rehabilitation Center maintains that each deficiency does not jeopardize the health and safety of the residents, nor is it of such character as to limit our capacity to provide adequate care.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0240 SS=B	A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. Based on observation and interview, the facility failed to serve residents their meals in a timely manor, resulting in Residents waiting 20 minutes for their meal to be served. This effected 2 Residents observed during 2 meal services in the main dining room. (Resident #42 and 59) Findings include: 1. During the noon meal service, on 7/19/11 at 12:30 P.M., Resident #59 was observed sitting at a table in the main dining room with Resident #124. Resident #124 was eating and Resident #59 was waiting for her meal to be brought to the table. At 12:50 P.M., Resident #59 was served her meal. The Resident had been waiting 20 minutes. During an interview with Resident #59, on 7/19/11 at 12:55 P.M., she indicated "I	F0240	I. Residents and staff inserviced related to meal tickets and the proper time frame for being served.II. All residents have the potential to be affected. See #3 III. Staff inserviced by 8-9-11 related to meal tickets and the proper time frame for timely serving of meal.IV. Dietary Manager or designee will observe 5 meals per week x 3 months and report to QA. Then 5 meals monthly until compliance is met and then remain on ongoing observation for QA review.V. Completion date: August 9, 2011	08/09/2011

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	don't know why I didn't get my food. I asked LPN #1 where my food was. It always takes a long time to get my food." 2. On 7/20/11 at 12:20 P.M., the lunch meal was observed in the main dining room. A. There were 3 tables in a row along the left side of the dining room: The first table in the row [closest to the door to the hallway] had 3 female residents sitting at the table. One of the residents had her lunch meal, and was eating the food. Resident #42 was one of the residents who did not have her lunch meal. The second table had 4 residents and 1 visitor sitting at the table. One resident had food and was eating. The third table [at the back of the room, in front of the partition to the assist area] had 4 residents sitting at the table. One resident had her lunch meal and was eating. B. There were 3 tables in a row down the middle of the room: The first table had 2 residents. Neither had their lunch meal.			

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	The second table had 3 residents. One had the lunch meal and was eating. The third table had 2 residents. One had food and was eating, the other did not have any food. In an interview on 7/20/11 at 12:40 P.M., regarding sitting at the table while her tablemate was eating, Resident #42 stated, "I guess we're just used to it." During an interview with the facility Administrator, on 7/22/11 at 3:00 P.M., she indicated the meal tickets are made out at the table when the Resident sits down at their table. The meal tickets are turned onto the kitchen and prepared in the order they are received. 3.1-32(a)			

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F0441 SS=D	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation and interview, the facility failed to ensure that 1 licensed nurse administered an insulin injection in a manner to prevent potential cross-contamination when she	F0441	I. Nursing staff inserviced related to proper insulin cap removal while maintaining appropriate Infection Control practices within 24 hours of notification of concern.II. All residents have the	08/05/2011

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	inappropriately held the syringe cap in her teeth before administering the insulin. This deficient practice impacted 1 of 1 resident randomly observed during a medication pass observation; and 1 of 2 licensed nurses observed administering insulin injections. [Resident #12; L.P.N. #1] Findings include: On 7/19/11 at 11:55 A.M., L.P.N. #1 was observed during the Medication Pass task while administering a sliding scale dose of insulin to Resident #12. The nurse correctly prepared the insulin at the medication cart, capping the needle after drawing up the required amount. The resident was not in her room on the unit. L.P.N. #1 located Resident #12 in the main dining room for the lunch meal. The nurse informed the resident that she would have to move her to a more private area, and pushed the resident in her wheelchair to an unoccupied office. After arriving in the office, L.P.N. #1 put the syringe cap in her mouth and held it between her teeth while she prepared the resident for the injection.		potential to be affected. see #3III. All current nursing staff will be re-inserviced by 8-5-11. New hire LPN/RNs will be inserviced relatetd to proper insulin cap removal while maintaining appropriate Infection Control practices.IV. DON or designee will observe Nurses providing insulin injections. This will occur with DON or designee observing 5 injections weekly x 3 months and report to QA. Then 5 injection observations monthly until compliance is met and then remain on ongoing observation for QA review.V. Completion date : August 5, 2011	

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	The nurse pulled the resident's top up to expose a small area of her abdomen, opened an alcohol packet, took the alcohol wipe out of the packet, and swabbed the skin. The nurse then pulled the syringe cap off using her teeth, exposed the needle, and administered the insulin. In an interview during the daily conference on 7/20/11 at 3:00 P.M., the Administrator and Director of Nursing indicated they had no policy/procedure related to this issue, but that licensed nurses should know not to hold a syringe in their teeth by the cap prior to administration of an injectable medication. On 7/21/11 at 9:15 A.M., the Director of Nursing provided a copy of an inservice she had completed with the current nurses scheduled. The inservice addressed "Proper Administration of Insulin" and covered "proper administration of insulin while providing privacy and proper infection control practices." In an interview at that time, the Director of Nursing indicated all nurses were reminded not to hold a syringe by their teeth. 3.1-18(b)			

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F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to document the notification of the physician regarding blood sugar levels that were out side the call parameters. This impacted 1 of 24 Resident reviewed for physician notification in a sample of 24. (Resident #110) Findings include: The clinical record of Resident #110 was reviewed on 7/20/11 at 1:30 P.M. Diagnoses for Resident #110 included, but were not limited to, diabetes, Alzheimer's disease and high blood pressure. A Physician's order, dated 1/4/10, indicated "Notify MD if BS (blood sugar) < [less than] 60 or > [greater than] 250."	F0514	I. Physician reviewed chart for resident #110 with new call orders obtained.II. All residents have the potential to be affected. See #3III. Current Nursing staff inserviced on 7-26-11 related to proper documentation of physician notification for blood sugars that are outside of parameters. New hire LPNs/RNs will be inserviced as above.IV. DON or designee will perform checks of blood sugar results to assure proper documentation of physician notification is completed. This will occur with DON or designee auditing 3 resident's blood sugar results weekly x 3 months and report to QA. Then auditing 3 resident's blood sugar results monthly until compliance is met and the remain on ongoing observation for QA review.V. Completion date: August 5, 2011	08/05/2011

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	A review of the Medication Administration Record (MAR), for the month of June 2011, indicated a BS over 250 three times. A review of the MAR, for the month of July 2011, indicated a BS over 250 ten times. A review of the Nursing notes, for the months of June and July 2011, did not indicated the physician had been notified of the BS above 250. During an interview with the Director of Nursing, on 7/22/11 at 9:15 A.M., she indicated the physician had been called but she could not find, in the chart, the documentation the physician had been notified regarding the BS above 250. 3.1-50(a)(1)			